PRINTED: 04/15/2011 FORM APPROVED AB NO. 0938-0391

DEFARTMENT OF HEALTH AND HUMAN SERVICES					
CENTERS FOR MEDICARE & MEDIC	AID SERVICES	OMB			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A DUH DING	COMPLETED		
	155050	A. BUILDING			

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		A. BUI	A. BUILDING B. WING		CON	COMPLETED 03/18/2011	
	PROVIDER OR SUPPLIER		p. wir	7519 W	IDDRESS, CITY, STATE, ZIP CODE INCHESTER ROAD VAYNE, IN46819	3		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F0000	This visit was for Complaint IN000	r the Investigation of 087833.	F00	000				
	1 ^	087833- Substantiated. iciencies related to the ed at F205.						
	Survey dates: Ma	arch 17, & 18, 2011						
	Facility number: Provider number AIM number:							
	Survey team: Christine Fodrea Angie Strass, RN	, RN TC I (March 18, 2011)						
	Census bed type: SNF/NF: 48 Total: 48							
	Census payor typ Medicare: 7 Medicaid: 38 Other: 3 Total: 48	oe:						
	Sample: 5							
	to be in substanti CFR, Part 483, S	h Care Center was found al compliance with 42 ubpart B in regard to the Complaint IN00087833.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4ULX11 Facility ID: 000250 If continuation sheet Page 1 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155359		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/18/2011		
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER ROAD FORT WAYNE, IN46819				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	cited in accordar	also reflects state findings are with 410 IAC 16.2. ompleted on March 21, alkner, RN.				

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
	155359		B. WING			03/18/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			7519 W	/INCHESTER ROAD		
	END HEALTH CARE		FORT WAYNE, IN46819				
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
F0205		ew and record review, the	F02	05	Preparation or execution of the plan of correction (POC) does not		04/04/2011
SS=A	_	ensure transfer discharge			constitute admission or assent by	the	
	•	ded to the responsible			provider to the truth, accuracy or	tiic	
		charge from the facility			veracity of the facts alleged or		
	for 1 of 4 residen	nts reviewed for discharge			conclusions set forth in the Stater		
	notification in a t	total sample of 5.			of Deficiences (SOD). The POC	is	
	(Resident #Z)			prepared and executed sole			
					because it is required by law.		
	Findings include	:			By this response, Riverbend Heal	th	
	S				Care Center acknowledges receip		
	Resident Z's reco	ord was reviewed			the SOD and alleges that it is in	. 01	
	3-17-2011 at 2:15 p.m. Resident #Z's				compliance. Accordingly, the PC	OC	
	diagnoses included but were not limited to			is submitted as alleged compliance as		e as	
	1				of April 13, 2011.		
	dementia with behavioral disturbances, high blood pressure and stroke.				D: 1 1H 14 C C 1		
					Riverbend Health Care Center		
					reserves the right to submit documentation to refute any of th	A	
		s note, dated 3-3-2011,			stated deficiencies on the SOD		
	indicated Resident #Z was transferred to				through formal appeal and or other	er	
	Generations on 3-3-2011 at 2:29 p.m.				administrative or legal proceeding		
	There was no indication the responsible						
	party had been contacted by the facility regarding transfer discharge rights.						
					F 205		
					Resident Identified no long	oer	
A "Resident Tran		nsfer Form," dated			resides at the facility. Charge Nu	_	
	3-3-2011, did not indicate Resident #Z				no longer works at facility.		
had been given transfer disc							
	notification.				2. Management Team review		
					Policy on Bed Hold Requirement	and	
	A "Bed Hold Policy" located in the ch				updated, when indicated.		
		•			Copy of bedhold policy attached	to	
	directly behind the "Resident Transfer Form" for Resident #Z was blank.				notice of transfer or discharge for		
	roini ioi keside	Resident #Z was blank.			and kept at nursing station		
		2 17 2011 + 2 22					
	In an interview o	on 3-17-2011 at 3:20 p.m.,			3. Nurses re-educated on Pol	icy	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
	155359		B. WING			03/18/2011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF PROVIDER OR SUPPLIER					INCHESTER ROAD		
RIVERBE	END HEALTH CAR	E CENTER	FORT WAYNE, IN46819				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the Administrato	r indicated the "Bed Hold			& Procedures of Bedhold		
	Policy" form sho	ould have been completed			requirement and notification, and		
	and given to the	responsible party.			Bedhold policy		
		T. P. C. S.			4 The DON on below 1		
	In an interview o	on 3-18-2011 at 8:49 a.m.,			4. The DON or designee will review any resident who transferre		
		ees Director indicated she			discharged from the facility throu		
					the morning Daily Clinical Meeti	-	
	*	contact Resident #Z's			and will identify and address any		
	1 1 1	on 3-3-2011 to request			issues or concerns, as indicated.		
		complete the "Bed Hold			Findings will be reported to RM/	QI	
	Policy." The So	ocial Services Director			committee		
	further indicated she was unable to reach						
	the responsible p	party either via home or					
	cell phone and had left a message for her				Completion date: April 13, 2011.		
	to return the call regarding the bed hold						
	policy. The Social Services Director						
	indicated Resident #Z's responsible party						
	had not returned her phone call.						
	A current policy entitled Bed Hold						
	Requirement and Notification, dated 1-11,						
	indicated "The resident/ patient and a						
	family member or legal representative						
	shall be given notice of the bed hold						
	option at the time of hospitalization or						
	therapeutic leave	∂					
	 This Federal Tag	relates to Complaint					
	IN00087833	, 12.2.00 to Complaint					
	1110000/033						
	2 1 12(0)(25)(4)						
	3.1-12(a)(25)(A)						
	3.1-12(a)(25)(B)						

000250